

**Affected Programs:** Wisconsin Chronic Disease Program

**To:** Individual Medical Supply Providers, Medical Equipment Vendors, Pharmacies

## **ForwardHealth Announces Changes to Prior Authorization and Claims Submission for Wisconsin Chronic Disease Program Enteral Nutrition Products**

This *ForwardHealth Update* announces changes to prior authorization and paper and electronic claims submission for Wisconsin Chronic Disease Program (WCDP) chronic renal disease, adult cystic fibrosis, and hemophilia home care providers of enteral nutrition products, effective October 2008, with the implementation of the ForwardHealth interChange system and the adoption of National Provider Identifiers.

This *Update* includes the following:

- A sample 1500 Health Insurance Claim Form (dated 08/05) and completion instructions.
- A revised Adjustment/Reconsideration Request, F-13046 (10/08), and completion instructions.
- A revised Prior Authorization Request Form (PA/RF), F-11018 (10/08), and completion instructions.
- A revised Prior Authorization Amendment Request, F-11042 (10/08).
- A revised Prior Authorization/Enteral Nutrition Product Attachment (PA/ENPA), F-11054 (10/08), and completion instructions.

A separate *Update* will give providers a calendar of important dates related to implementation.

Information in this *Update* applies to providers who provide services for WCDP members.

### **Implementation of ForwardHealth interChange**

In October 2008, the Department of Health Services (DHS) will implement ForwardHealth interChange, which replaces Wisconsin's existing Medicaid Management Information System (MMIS).

ForwardHealth interChange will be supported as part of the State's new fiscal agent contract with EDS. With ForwardHealth interChange, providers and trading partners will have more ways to verify member enrollment and submit electronic claims, adjustments, and prior authorization (PA) requests through the secure ForwardHealth Portal. Refer to the March 2008 *ForwardHealth Update* (2008-24), titled "Introducing ForwardHealth interChange, a New Web-Based Information System for State Health Care Programs," for an overview of the implementation and a more detailed outline of the many business process enhancements and added benefits the new system and fiscal agent contract will provide.

With the implementation of the ForwardHealth interChange system, important changes will be made to PA and paper and electronic claims submission procedures that are detailed in this *Update*. These changes are not policy or coverage related.

Wisconsin Chronic Disease Program (WCDP) providers are reminded that WCDP covers services directly related to chronic renal disease, adult cystic fibrosis, and hemophilia home care only. Enteral nutrition products are covered for members who are enrolled in the chronic renal disease program of WCDP.

Providers may use any of the following methods to submit claims after the October 2008 implementation of ForwardHealth interChange:

- Electronic, using one of the following:
  - ✓ Online claim submission through the ForwardHealth Portal. This is a **new** claim submission option available with the implementation of ForwardHealth interChange.
  - ✓ Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant claim transaction submissions through Electronic Data Interchange.
  - ✓ Provider Electronic Solutions (PES) software. This is a **new** claim submission option available with the implementation of ForwardHealth interChange.
- Paper, using the 1500 Health Insurance Claim Form (dated 08/05).

The PES software accommodates changes that result from the implementation of ForwardHealth interChange and National Provider Identifiers (NPIs). Provider Electronic Solutions software is available to providers and electronic billing services at no cost. Using PES software, providers may submit HIPAA-compliant electronic claims and adjustments to ForwardHealth. The PES software cannot be used to submit claims to Medicare or commercial health insurance payers.

Wisconsin Chronic Disease Program providers should refer to the ForwardHealth companion documents for more information about electronic transactions. Wisconsin Chronic Disease Program will no longer issue separate companion documents. Companion documents provide software firms, billing services and

clearinghouses, and computer processing staff (known as trading partners) who manage the technical component (e.g., telecommunication, exchange file creation, translation) of electronic transactions with useful technical information about ForwardHealth's standards for HIPAA-compliant transactions. Companion documents include information to help trading partners to successfully exchange HIPAA-compliant electronic transactions with ForwardHealth.

### **General Changes for Claims Submission**

Unless otherwise indicated, the following information applies to both paper and electronic claims submission for providers who provide services for WCDP members.

Providers are reminded that a Healthcare Common Procedure Coding System (HCPCS) "B" code should be indicated on claims submitted to WCDP for enteral nutrition products.

*Note:* Providers should only use these instructions for claims received following implementation of ForwardHealth interChange. Following these procedures prior to implementation will result in the claim being denied.

### ***Elimination of Prior Authorization Number on Claims***

Providers will no longer be required to indicate a PA number on claims. ForwardHealth's paper Remittance Advice and the 835 Health Care Claim Payment/Advice will report to the provider the PA number used to process the claim. If a PA number is indicated on a claim, it will not be used and it will have no effect on processing the claim.

### ***Elimination of M-6 Medicare Disclaimer Code***

Medicare disclaimer code "M-6" (Recipient not Medicare eligible), previously disclaimer code "6" for WCDP providers, has been eliminated. The only allowable Medicare disclaimer codes in the ForwardHealth

interChange system will consist of “M-7” (Medicare disallowed or denied payment) and “M-8” (Noncovered Medicare service). Wisconsin Chronic Disease Program providers should note that if the “M-6” disclaimer code is indicated on the claim, the claim will be denied.

### ***Elimination of Series Billing***

ForwardHealth will accept multi-page claims with as many as 50 details on a 1500 Health Insurance Claim Form; therefore, series billing (i.e., allowing providers to indicate up to four dates of service [DOS] per detail line) is no longer necessary and will no longer be accepted. Claims submitted with series billing will be denied. Single and range dates on claims will be accepted.

### ***Provider Identifiers***

The referring provider’s NPI is required on claims. The claim will be denied if the referring provider’s NPI is not indicated or if the NPI is invalid.

### ***Valid Procedure Codes and Modifiers***

Valid procedure codes and modifiers from national code sets must be indicated on claims. Claims submitted with invalid codes will be denied.

### **1500 Health Insurance Claim Form Changes**

Following the implementation of ForwardHealth interChange, providers submitting paper claims will be required to use the 1500 Health Insurance Claim Form (dated 08/05) with the instructions included in this *Update*. Claims received on the CMS 1500 claim form (dated 12/90) after implementation will be returned to the provider unprocessed.

Refer to Attachments 1 and 2 of this *Update* for completion instructions and a sample 1500 Health Insurance Claim Form for WCDP enteral nutrition products.

*Note:* Providers should only use these instructions for claims received following ForwardHealth interChange

implementation. Following these procedures prior to implementation will result in the claim being denied. A future *Update* will include a calendar of important dates related to implementation.

### ***Other Insurance Indicators***

With the implementation of interChange, other insurance indicator codes will change for WCDP providers. If Wisconsin’s Enrollment Verification System (EVS) indicates that the member has Wausau Health Protection Plan (“HPP”), BlueCross & BlueShield (“BLU”), Wisconsin Physicians Service (“WPS”), Medicare Supplement (“SUP”), TriCare (“CHA”), Vision only (“VIS”), a health maintenance organization (“HMO”), or some other (“OTH”) commercial health insurance, and the service requires other insurance billing, one of the following three other insurance (OI) explanation codes must be indicated in the first box of Element 9 of the claim:

- OI-P.
- OI-D.
- OI-Y.

### ***Referring Providers***

A referring provider’s name and NPI must be indicated on claims for enteral nutrition products.

### ***Valid Diagnosis Codes Required***

ForwardHealth will monitor claims submitted on the 1500 Health Insurance Claim Form for the most specific *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis codes for all diagnoses. The required use of valid diagnosis codes includes the use of the most specific diagnosis codes. Valid, most specific diagnosis codes may have up to five digits. Claims submitted with three- or four-digit codes where four- and five-digit codes are available may be denied.

### ***Diagnosis Code Pointer Changes***

ForwardHealth will accept up to eight diagnosis codes in Element 21 of the 1500 Health Insurance Claim Form. To add additional diagnosis codes in this element,

providers should indicate the fifth diagnosis code between the first and third diagnosis code blanks, the sixth diagnosis code between the second and fourth diagnosis code blanks, the seventh diagnosis code to the right of the third diagnosis code blank, and the eighth diagnosis code to the right of the fourth diagnosis code blank. Providers should not number any additional diagnosis codes.

In Element 24E of the 1500 Health Insurance Claim Form, providers may indicate up to four diagnosis pointers per detail line. Valid diagnosis pointers are digits 1 through 8; digits should not be separated by commas or spaces. Services without a diagnosis pointer will be denied.

### ***Valid Place of Service Codes***

Providers are required to indicate a two-digit place of service (POS) code on claims for WCDP enteral nutrition products. Refer to Attachment 3 for a list of allowable POS codes for WCDP enteral nutrition products.

### ***Indicating Quantities***

When indicating units in Element 24G, only use a decimal when billing fractions; for example, enter “1.50” to indicate one and a half units. For whole units, simply enter the number; for example, enter “150” to indicate 150 units.

The detail quantity indicated on the claim must be evenly divisible by the number of days billed on the claim.

### ***Usual and Customary Charges***

Wisconsin Chronic Disease Program providers should indicate their usual and customary charges on claims. The usual and customary charge is the provider’s charge for providing the same service to persons not entitled to WCDP benefits.

### ***Billed Amounts***

The detail billed amount indicated on the claim must be evenly divisible by the number of days billed on the claim.

### ***Medicare Crossover Claims***

#### ***Signature and Date Required***

A provider signature and date is now required on all provider submitted claims, including all Medicare crossover claims submitted by providers on the 1500 Health Insurance Claim Form and processed after ForwardHealth interChange implementation. The words “signature on file” will no longer be acceptable. Provider-submitted crossover claims without a signature or date will be denied or be subject to recoupment.

#### ***Submission***

Providers are required to submit an Explanation of Medicare Benefits (EOMB) to WCDP with Medicare crossover claims. An EOMB should not be submitted with a claim that has not crossed over to Medicare.

### ***Adjustment/Reconsideration Request Changes***

Providers will be required to use the revised Adjustment/Reconsideration Request, F-13046 (10/08). The Adjustment/Reconsideration Request was revised to be able to be used by all ForwardHealth providers to request an adjustment of an allowed claim (a paid or partially paid claim). An adjustment or reconsideration request received in any other format will be returned to the provider unprocessed.

Refer to Attachments 4 and 5 for the revised Adjustment/Reconsideration Request Completion Instructions, F-13046A (10/08), and the Adjustment/Reconsideration Request.

## **Prior Authorization**

### ***Submitting Prior Authorization Requests***

Wisconsin Chronic Disease Program providers will be able to submit PA requests for enteral nutrition products using the ForwardHealth Portal.

In addition to the Portal, providers may submit PA requests via any of the following:

- Fax at (608) 221-8616.
- Mail to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

Watch for future publications for information on submitting PA requests via the Portal.

*Note:* Specific implementation dates will be published in a separate *Update*. Use of information presented in this *Update* prior to implementation may result in returned PA requests.

### ***Prior Authorization Numbers***

The PA number will no longer be pre-printed on the Prior Authorization Request Form (PA/RF), F-11018 (10/08). As a result, providers will be able to download and print the form from the Portal and no longer have to order pre-printed forms from ForwardHealth. Upon receipt of the form, ForwardHealth will assign a PA number to each PA request.

The PA number will consist of 10 digits, containing valuable information about the PA (e.g., the date the PA request was received by ForwardHealth, the medium used to submit the PA request). Refer to Attachment 6 for information about interpreting PA numbers.

## ***Changes to Prior Authorization Forms***

With the implementation of ForwardHealth interChange, providers submitting a paper PA request for enteral nutrition products will be required to use the revised PA/RF. Refer to Attachments 7 and 8 for completion instructions and a copy of the PA/RF for providers to photocopy. Attachment 9 is a sample PA/RF for WCDP enteral nutrition products.

*Note:* If ForwardHealth receives a PA request on a previous version of the PA/RF, a letter will be sent to the provider stating that the provider is required to submit a new PA request using the proper forms. This may result in a later grant date if the PA request is approved.

### ***Revisions to the Prior Authorization Request Form and Instructions***

The following revisions have been made to the PA/RF:

- The PA number is eliminated from the form.
- The paper PA/RF is a one-part form (no longer a two-part, carbonless form) that can be downloaded and printed. The PA/RF is available in two formats on the Portal — Microsoft® Word and Portable Document Format (PDF).
- Checkboxes are added for HealthCheck “Other Services” and Wisconsin Chronic Disease Program (WCDP) (Element 1) to create efficiencies for providers who render services to members in Wisconsin Medicaid, BadgerCare Plus, and WCDP.
- The term “rendering provider” replaces “performing provider” to align with HIPAA terminology.
- Billing and rendering provider taxonomy code fields are added (Elements 5b and 17) to accommodate NPI implementation.
- In the billing provider’s name and address fields, providers are now required to include the ZIP +4 code (Element 4) to accommodate NPI implementation.

### *Prior Authorization Attachments*

With the implementation of ForwardHealth interChange, providers submitting a paper PA request for enteral nutrition products will be required to use the revised Prior Authorization/Enteral Nutrition Product Attachment (PA/ENPA), F-11054 (10/08). While the basic information requested on the form has not changed, the format of the form has changed to accommodate NPI information and to add a barcode. ForwardHealth will scan each form with a barcode as it is received, which will allow greater efficiencies for processing PA requests.

Refer to Attachment 10 for a copy of the completion instructions for the PA/ENPA. Attachment 11 is a copy of the PA/ENPA for providers to photocopy.

### ***Obtaining Prior Authorization Request Forms and Attachments***

The PA/RF and PA/ENPA are available in fillable PDF or fillable Microsoft® Word from the Forms page at [dhfs.wisconsin.gov/ForwardHealth/](http://dhfs.wisconsin.gov/ForwardHealth/) prior to implementation and will be available from the Portal after implementation.

The fillable PDF is accessible using Adobe Reader® and may be completed electronically.

To request a paper copy of the PA/RF or PA/ENPA for photocopying, call Provider Services at (800) 947-9627. Questions about the forms may also be directed to Provider Services.

In addition, a copy of any PA form and/or attachment is available by writing to ForwardHealth. Include a return address, the name of the form, and the number of the

form (if applicable) and mail the request to the following address:

ForwardHealth  
Form Reorder  
6406 Bridge Rd  
Madison WI 53784-0003

### ***Prior Authorization Decisions***

The PA review process continues to include both a clerical review and a clinical review. The PA request will have one of the statuses detailed in the following table.

<b>Prior Authorization Status</b>	<b>Description</b>
Approved	The PA request was approved as requested.
Approved with Modifications	The PA request was approved with modifications to what was requested.
Denied	The PA request was denied.
Returned — Provider Review	The PA request was returned to the provider for correction or for additional information.
Pending — Fiscal Agent Review	The PA request is being reviewed by the Fiscal Agent.
Pending — Dental Follow-up	The PA request is being reviewed by a Fiscal Agent dental specialist.
Pending — State Review	The PA request is being reviewed by the State.
Suspend — Provider Sending Information	The PA request was submitted via the ForwardHealth Portal and the provider indicated they will be sending additional supporting information on paper.
Inactive	The PA request is inactive due to no response within 30 days to the returned provider review letter and cannot be used for PA or claims processing.

## ***Communicating Prior Authorization Decisions***

ForwardHealth will make a decision regarding a provider's PA request within 20 working days from the receipt of all the necessary information. After processing the PA request, ForwardHealth will send the provider either a decision notice letter or a returned provider review letter. Providers will receive a decision notice letter for PA requests that were approved, approved with modifications, or denied. Providers will receive a returned provider review letter for PA requests that require corrections or additional information. The new decision notice letter or returned provider review letter implemented with ForwardHealth interChange will clearly indicate what is approved or what correction or additional information ForwardHealth needs to continue adjudicating the PA request.

Providers submitting PA requests via the Portal will receive a decision notice letter or returned provider review letter via the Portal.

If the provider submitted a PA request via mail or fax and the provider has a Portal account, the decision notice letter or returned provider review letter will be sent to the provider via the Portal as well as by mail.

If the provider submitted a paper PA request via mail or fax and does not have a Portal account, the decision notice letter or returned provider review letter will be sent to the address indicated in the provider's file as his or her PA address (or to the physical address if there is no PA address on file), *not* to the address the provider wrote on the PA request.

The decision notice letter or returned provider review letter will not be faxed back to providers who submitted their paper PA request via fax. Providers who submitted their paper PA request via fax will receive the decision notice letter or returned provider letter via mail.

## *Returned Provider Review Letter*

The returned provider review letter will indicate the PA number assigned to the request and will specify corrections or additional information needed on the PA request. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth. Providers can also correct PAs that have been placed in returned provider review status in the Portal.

The provider's paper documents submitted with the PA request will no longer be returned to the provider when corrections or additional information are needed. Therefore, providers are required to make a copy of their PA requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if ForwardHealth requires more information about the PA request.

*Note:* When changing or correcting the PA request, providers are reminded to revise or update the documentation retained in their records.

## *Thirty Days to Respond to the Returned Provider Review Letter*

ForwardHealth must receive the provider's response within 30 calendar days of the date on the returned provider review letter, whether the letter was sent to the provider by mail or through the Portal. If the provider's response is received within 30 calendar days, ForwardHealth will still consider the original receipt date on the PA request when authorizing a grant date for the PA.

If ForwardHealth does not receive the provider's response within 30 calendar days of the date the returned provider review letter was sent, the PA status becomes inactive and the provider is required to submit a new PA request. This will result in a later grant date if the PA request is approved. Providers will not be notified when

their PA request status changes to inactive, but this information will be available on the Portal and through the WiCall Automated Voice Response system. Watch for future publications for more information regarding checking PA status via WiCall.

If ForwardHealth receives additional information from the provider after the 30-day deadline has passed, a letter will be sent to the provider stating that the PA request is inactive and the provider is required to submit a new PA request.

#### *Listing Procedure Codes Approved as a Group on the Decision Notice Letter*

In certain circumstances, ForwardHealth will approve a PA request for a group of procedure codes with a total quantity approved for the entire group. When this occurs, the quantity approved for the entire group of codes will be indicated with the first procedure code. All of the other approved procedure codes within the group will indicate a quantity of zero.

Providers may submit claims for any combination of the procedure codes in the group up to the approved quantity.

#### ***New Amendment Process***

Providers are required to use the Prior Authorization Amendment Request, F-11042 (10/08), to amend an approved or modified PA request. The Prior Authorization Amendment Request was revised to accommodate NPI information.

Instructions for completion of the Prior Authorization Amendment Request are located in Attachment 12. Attachment 13 is a copy of the revised Prior Authorization Amendment Request for providers to photocopy.

ForwardHealth does not accept a paper amendment request submitted on anything other than the Prior Authorization Amendment Request. The Prior Authorization Amendment Request may be submitted

through the Portal as well as by mail or fax. If ForwardHealth receives a PA amendment on a previous version of the Prior Authorization Amendment Request form, a letter will be sent to the provider stating that the provider is required to submit a new PA amendment request using the proper forms.

ForwardHealth will make a decision regarding a provider's amendment request within 20 working days from the receipt of all the information necessary. If the provider submitted the amendment request via the Portal, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal.

If the provider submitted an amendment request via mail or fax and the provider has a Portal account, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal as well as by mail.

If the provider submitted a paper amendment request via mail or fax and does not have a Portal account, the decision notice letter or returned amendment provider review letter will be sent to the address indicated in the provider's file as his or her PA address (or to the physical address if there is no PA address on file), *not* to the address the provider wrote on the amendment request.

Neither the decision notice letter nor the returned amendment provider review letter will be faxed back to providers who submitted their paper amendment request via fax. Providers who submitted their paper amendment request via fax will receive the decision notice letter or returned amendment provider review letter via mail.

#### *Returned Amendment Provider Review Letter*

If the amendment request needs correction or additional information, a returned amendment provider review letter will be sent. The letter will show how the PA appears currently in the system and providers are required to respond by correcting errors identified on

the letter. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth. Providers can also correct an amendment request that has been placed in returned provider review status in the Portal.

ForwardHealth must receive the provider's response within 30 calendar days of the date the returned amendment provider review letter was sent. After 30 days the amendment request status becomes inactive and the provider is required to submit a new amendment request. The ForwardHealth interChange system will continue to use the original approved PA request for processing claims.

The provider's paper documents submitted with the amendment request will no longer be returned to the provider when corrections or additional information are needed. Therefore, providers are required to make a copy of their amendment requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if ForwardHealth requires more information about the amendment request.

*Note:* When changing or correcting the amendment request, providers are reminded to revise or update the documentation retained in their records.

### ***Valid Diagnosis Codes Required***

Effective with implementation, the PA/RF will be monitored for the most specific *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis codes for all diagnoses. The required use of valid diagnosis codes includes the use of the most specific diagnosis codes. Valid, most specific, diagnosis codes may have up to five digits.

Prior authorization requests sent by mail or fax with an invalid diagnosis code will be returned to the provider. Providers using the Portal will receive a message that the diagnosis code is invalid and will be allowed to correct the code and submit the PA request.

### ***Enhanced Reimbursement for Selected Pediatric Products***

All enteral nutrition products require PA. Enhanced reimbursement is available for select medically necessary pediatric enteral nutrition products for which there are no substitutes and the maximum allowable fee does not adequately cover the provider's wholesale costs.

Pediatric products are limited to members up to age 21.

#### *New Prior Authorization Requests*

When requesting PA with enhanced reimbursement, (modifier "SC") providers should do the following:

- Complete the PA/RF and the PA/ENPA. Indicate the modifier "SC" on the PA/RF.
- Attach a copy of the provider's invoice indicating the wholesale cost.
- Attach documentation to demonstrate one of the following:
  - ✓ The member has experienced treatment failure or feeding intolerance with a more cost-effective product.
  - ✓ The member has a medical condition(s) that prevents the use of a more cost-effective product.
  - ✓ The member has experienced unacceptable side effects while on the more cost-effective product.

If WCDP approves the PA request with the enhanced reimbursement, the PA consultant will manually price the product based on the invoice. Wisconsin Chronic Disease Program will reimburse the provider the invoice price in addition to a fee based on the pharmacy dispensing fee.

### *Currently Approved Prior Authorization Requests*

If providers have a currently approved PA for an enteral nutrition product for which enhanced reimbursement is available, providers may request an amendment of the currently approved or modified PA. The amendment request should include the following:

- A copy of the currently approved PA/RF.
- Specific changes to the PA being requested including a request to add the “SC” modifier to the applicable procedure code(s).
- A document explaining or justifying the requested changes providing the information outlined previously.
- A copy of the provider’s invoice indicating the wholesale cost.

### *Claims Submission*

If WCDP approves the PA request for enhanced reimbursement, the provider may then provide the service and submit claims with the “SC” modifier. If WCDP approves the PA request for the product, but not the enhanced reimbursement, the claim must be submitted without the “SC” modifier. If the provider submits a PA amendment request, he or she is required to wait until the request is approved before adjusting any paid claims to add the “SC” modifier.

The “SC” modifier may be billed with other modifiers, such as the “BO” modifier.

### *Automatic Crossover Claims*

If WCDP is the only other payer known to Medicare, and a claim includes the “SC” modifier, the provider should submit the claim to Medicare first *without* using the “SC” modifier as Medicare does not recognize the modifier and will not transmit the modifier to WCDP on the automatic crossover claim. After WCDP processes and pays the crossover claim without the modifier, the provider can submit an Adjustment/Reconsideration Request to WCDP to add the “SC” modifier.

If the claim does not automatically cross over from Medicare to WCDP, the provider should submit the crossover claim to WCDP with the “SC” modifier.

### **Reimbursement**

Wisconsin Chronic Disease Program has established maximum allowable fees for enteral nutrition products based on Medicare rates.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at [dhs.wisconsin.gov/forwardhealth/](http://dhs.wisconsin.gov/forwardhealth/).

P-1250

# ATTACHMENT 1

## 1500 Health Insurance Claim Form Completion Instructions for Wisconsin Chronic Disease Program Enteral Nutrition Products Effective for claims received on and after implementation of ForwardHealth interChange.

Use the following claim form completion instructions, not the claim form's printed descriptions, to avoid denial or inaccurate claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so.

Members enrolled in Wisconsin Chronic Disease Program (WCDP) receive a ForwardHealth identification card. Always verify a member's enrollment before providing nonemergency services to determine if there are any limitations on covered services and to obtain the correct spelling of the member's name. Refer to the Online Handbook in the Provider area of the ForwardHealth Portal at [www.forwardhealth.wi.gov/](http://www.forwardhealth.wi.gov/) for more information about verifying enrollment.

*When submitting a claim with multiple pages, providers are required to indicate page numbers using the format "Page X of X" in the upper right corner of the claim form.*

Submit completed paper claims to the following address:

WCDP  
PO Box 6410  
Madison WI 53716-0410

### **Element 1 — Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Blk Lung, Other**

Enter "C" in the Other check box.

### **Element 1a — Insured's ID Number**

Enter the member identification number. Do not enter any other numbers or letters. Use the ForwardHealth card or Wisconsin's Enrollment Verification System (EVS) to obtain the correct member ID.

### **Element 2 — Patient's Name**

Enter the member's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

### **Element 3 — Patient's Birth Date, Sex**

Enter the member's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/CCYY format (e.g., February 3, 1955, would be 02/03/1955). Specify whether the member is male or female by placing an "X" in the appropriate box.

**Element 4 — Insured’s Name**

Data are required in this element for Optical Character Recognition (OCR) processing. Any information populated by a provider’s computer software is acceptable data for this element (e.g., “Same”). If computer software does not automatically complete this element, enter information such as the member’s last name, first name, and middle initial.

**Element 5 — Patient’s Address**

Enter the complete address of the member’s place of residence, if known.

**Element 6 — Patient Relationship to Insured (not required)****Element 7 — Insured’s Address (not required)****Element 8 — Patient Status (not required)****Element 9 — Other Insured’s Name (not required)****Element 9a — Other Insured’s Policy or Group Number (not required)****Element 9b — Other Insured’s Date of Birth, Sex (not required)****Element 9c — Employer’s Name or School Name (not required)****Element 9d — Insurance Plan Name or Program Name (not required)****Element 10a-10c — Is Patient’s Condition Related to: (not required)****Element 10d — Reserved for Local Use (not required)****Element 11 — Insured’s Policy Group or FECA Number**

Use the first box of this element only. (Elements 11a, 11b, 11c, and 11d are not required.) Element 11 should be left blank when one or more of the following statements are true:

- Medicare never covers the procedure in any circumstance.
- ForwardHealth indicates the member does *not* have any Medicare coverage including Medicare Cost (“MCC”) or Medicare + Choice (“MPC”) for the service provided. For example, the service is covered by Medicare Part A, but the member does not have Medicare Part A.
- ForwardHealth indicates that the provider is not Medicare enrolled.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

If none of the previous statements are true, a Medicare disclaimer code is necessary. If submitting a multiple-page claim, indicate Medicare disclaimer codes on the *first page* of the claim. The following Medicare disclaimer codes may be used when appropriate.

Code	Description
<b>M-7</b>	<p><b>Medicare disallowed or denied payment.</b> This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the member's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted.</p> <p><i>For Medicare Part A, use M-7 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> <li>The provider is identified in ForwardHealth files as certified for Medicare Part A.</li> <li>The member is eligible for Medicare Part A.</li> <li>The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or exhausted benefits.</li> </ul> <p><i>For Medicare Part B, use M-7 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> <li>The provider is identified in ForwardHealth files as certified for Medicare Part B.</li> <li>The member is eligible for Medicare Part B.</li> <li>The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or exhausted benefits.</li> </ul>
<b>M-8</b>	<p><b>Noncovered Medicare service.</b> This code may be used when Medicare was not billed because the service is not covered in this circumstance.</p> <p><i>For Medicare Part A, use M-8 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> <li>The provider is identified in ForwardHealth files as certified for Medicare Part A.</li> <li>The member is eligible for Medicare Part A.</li> <li>The service is usually covered by Medicare Part A but not in this circumstance (e.g., member's diagnosis).</li> </ul> <p><i>For Medicare Part B, use M-8 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> <li>The provider is identified in ForwardHealth files as certified for Medicare Part B.</li> <li>The member is eligible for Medicare Part B.</li> <li>The service is usually covered by Medicare Part B but not in this circumstance (e.g., member's diagnosis).</li> </ul>

**Element 11a — Insured's Date of Birth, Sex (not required)**

**Element 11b — Employer's Name or School Name (not required)**

**Element 11c — Insurance Plan Name or Program Name (not required)**

**Element 11d — Is there another Health Benefit Plan? (not required)**

**Element 12 — Patient's or Authorized Person's Signature (not required)**

**Element 13 — Insured's or Authorized Person's Signature (not required)**

**Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)**

**Element 15 — If Patient Has Had Same or Similar Illness (not required)**

**Element 16 — Dates Patient Unable to Work in Current Occupation (not required)**

**Element 17 — Name of Referring Provider or Other Source**

Enter the referring physician's name.

**Element 17a — (not required)**

**Element 17b — NPI**

Enter the National Provider Identifier (NPI) of the referring physician.

## **Element 18 — Hospitalization Dates Related to Current Services (not required)**

### **Element 19 — Reserved for Local Use**

If a provider bills an unlisted (or not otherwise specified) procedure code, a description of the procedure must be indicated in this element. If Element 19 does not provide enough space for the procedure description, or if a provider is billing multiple unlisted procedure codes, documentation must be attached to the claim describing the procedure(s). In this instance, indicate “See Attachment” in Element 19.

### **Element 20 — Outside Lab? \$Charges (not required)**

### **Element 21 — Diagnosis or Nature of Illness or Injury**

Enter a valid *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. The required use of valid diagnosis codes includes the use of the most specific diagnosis codes. List the primary diagnosis first. Etiology (“E”) and manifestation (“M”) codes may not be used as a primary diagnosis. The diagnosis description is not required.

ForwardHealth accepts up to eight diagnosis codes. To enter more than four diagnosis codes:

- Enter the fifth diagnosis code in the space *between* the first and third diagnosis codes.
- Enter the sixth diagnosis code in the space *between* the second and fourth diagnosis codes.
- Enter the seventh diagnosis code in the space to the right of the third diagnosis code.
- Enter the eighth diagnosis code in the space to the right of the fourth diagnosis code.

When entering fifth, sixth, seventh, and eighth diagnosis codes, do *not* number the diagnosis codes (e.g., do not include a “5.” before the fifth diagnosis code).

### **Element 22 — Medicaid Resubmission (not required)**

### **Element 23 — Prior Authorization Number (not required)**

### **Element 24**

The six service lines in Element 24 have been divided horizontally. Enter service information in the bottom, unshaded area of the six service lines. The horizontal division of each service line is not intended to allow the billing of 12 lines of service.

#### **Element 24A — Date(s) of Service**

Enter to and from dates of service (DOS) in MM/DD/YY or MM/DD/CCYY format. If the service was provided on only one DOS, enter the date under "From." Leave "To" blank or re-enter the "From" date.

If the service was provided on consecutive days, those dates may be indicated as a range of dates by entering the first date as the "From" DOS and the last date as the "To" DOS in MM/DD/YY or MM/DD/CCYY format.

A range of dates may be indicated only if the place of service (POS), the procedure code (and modifiers, if applicable), the charge, the units, and the rendering provider were identical for each DOS within the range.

#### **Element 24B — Place of Service**

Enter the appropriate two-digit POS code for each item used or service performed.

**Element 24C — EMG**

Enter a “Y” for each procedure performed as an emergency. If the procedure was not an emergency, leave this element blank.

**Element 24D — Procedures, Services, or Supplies**

Enter the single most appropriate five-character procedure code. ForwardHealth denies claims received without an appropriate procedure code.

**Modifiers**

Enter the appropriate (up to four per procedure code) modifier(s) in the “Modifier” column of Element 24D.

**Element 24E — Diagnosis Pointer**

Enter the number(s) that corresponds to the appropriate ICD-9-CM diagnosis code(s) listed in Element 21. Up to four diagnosis pointers per detail may be indicated. Valid diagnosis pointers, digits 1 through 8, should *not* be separated by commas or spaces.

**Element 24F — \$ Charges**

Enter the total charge for each line item.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter “00” in the cents area if the amount is a whole number.

Providers are to bill ForwardHealth their usual and customary charge. The usual and customary charge is the provider’s charge for providing the same service to persons not entitled to ForwardHealth benefits.

**Element 24G — Days or Units**

Enter the appropriate number of units. Only include a decimal when billing fractions (e.g., 1.50).

**Element 24H — EPSDT/Family Plan (not required)****Element 24I — ID Qual**

If the rendering provider’s NPI is different than the billing provider number in Element 33A, enter a qualifier of “ZZ,” indicating provider taxonomy, in the *shaded area* of the detail line.

**Element 24J — Rendering Provider ID. #**

If the rendering provider’s NPI is different than the billing provider number in Element 33A, enter the rendering provider’s 10-digit taxonomy code in the *shaded area* of this element and enter the rendering provider’s NPI in the *white area* provided for the NPI.

**Element 25 — Federal Tax ID Number (not required)****Element 26 — Patient’s Account No. (not required)**

Optional — Providers may enter up to 14 characters of the patient’s internal office account number. This number will appear on the Remittance Advice and/or the 835 Health Care Claim Payment/Advice transaction.

**Element 27 — Accept Assignment? (not required)****Element 28 — Total Charge**

Enter the total charges for this claim. If submitting a multiple-page claim, enter the total charge for the claim (i.e., the sum of all details from all pages of the claim) *only on the last page of the claim*.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter “00” in the cents area if the amount is a whole number.

**Element 29 — Amount Paid (not required)**

**Element 30 — Balance Due**

Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28. If submitting a multiple-page claim, enter the balance due for the claim (i.e., the sum of all details from all pages of the claim minus the amount paid by commercial insurance) *only on the last page of the claim*.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter “00” in the cents area if the amount is a whole number.

**Element 31 — Signature of Physician or Supplier, Including Degrees or Credentials**

The provider or authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/CCYY format.

*Note:* The signature may be a computer-printed or typed name and date or a signature stamp with the date.

**Element 32 — Service Facility Location Information (not required)**

**Element 32a — NPI (not required)**

**Element 32b — (not required)**

**Element 33 — Billing Provider Info & Ph #**

Enter the name of the provider submitting the claim and the practice location address. The minimum requirement is the provider's name, street, city, state, and ZIP + 4 code.

**Element 33a — NPI**

Enter the NPI of the billing provider.

**Element 33b**

Enter qualifier “ZZ” followed by the 10-digit provider taxonomy code.

Do not include a space between the qualifier (“ZZ”) and the provider taxonomy code.

# ATTACHMENT 2

## Sample 1500 Health Insurance Claim Form for Wisconsin Chronic Disease Program Enteral Nutrition Products

**1500**

### HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA		PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>1234567890</b>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>MEMBER, IM A</b>		3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>SAME</b>		5. PATIENT'S ADDRESS (No., Street) <b>609 WILLOW ST</b>	
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
10. IS PATIENT'S CONDITION RELATED TO: Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER <b>M-8</b>	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED _____	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE <b>I.M. REFERRING PROVIDER</b>		17a. NPI <b>0111111110</b>	
19. RESERVED FOR LOCAL USE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. <b>585.1</b>		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER E. DIAGNOSIS POINTER		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
25. FEDERAL TAX I.D. NUMBER SSN E IN		23. PRIOR AUTHORIZATION NUMBER	
26. PATIENT'S ACCOUNT NO. <b>1234JED</b>		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>	
28. TOTAL CHARGE \$ <b>XX XX</b>		29. AMOUNT PAID \$	
30. BALANCE DUE \$ <b>XX XX</b>		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <b>I.M. Provider MM/DD/YY</b>	
32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # <b>I.M. PROVIDER</b> <b>1 W WILLIAMS ST</b> <b>ANYTOWN WI 55555-1234</b>	
SIGNED _____ DATE _____		a. <b>0222222220</b> b. <b>ZZ12345679X</b>	

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

# **ATTACHMENT 3**

## **Allowable Place of Service Codes for Wisconsin Chronic Disease Program Enteral Nutrition Products**

The following table lists the nationally recognized two-digit place of service codes that providers should indicate on claims submitted to Wisconsin Chronic Disease Program for enteral nutrition products.

<b>Code</b>	<b>Description</b>
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
50	Federally Qualified Health Center
72	Rural Health Clinic
99	Other Place of Service

# **ATTACHMENT 4**

## **Adjustment/Reconsideration Request Completion Instructions**

(A copy of the “Adjustment/Reconsideration Request Completion Instructions” is located on the following pages.)

(This page was intentionally left blank.)

**FORWARDHEALTH**  
**ADJUSTMENT / RECONSIDERATION REQUEST COMPLETION INSTRUCTIONS**

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

ForwardHealth members are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and member number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

The Adjustment/Reconsideration Request, F-13046, is used by ForwardHealth to request an adjustment of an allowed claim (a paid or partially paid claim). Providers may request an adjustment when claim data need to be changed or corrected. After the changes are made to the original claim, the adjusted claim is processed.

Providers cannot adjust a totally denied claim. A claim that was totally denied must be resubmitted after the necessary corrections have been made.

Questions about adjustments and other procedures or policies may be directed to Provider Services at (800) 947-9627.

The Adjustment/Reconsideration Request is reviewed by ForwardHealth based on the information provided. Providers may photocopy the Adjustment/Reconsideration Request for their own use. Providers should be as specific as possible when describing how the original claim is to be changed. Providers may also attach a copy of the corrected claim.

The provider is required to maintain a copy of this form for his or her records.

The provider should mail the Adjustment/Reconsideration Request to the appropriate mailing address:

BadgerCare Plus  
Claims and Adjustments  
6406 Bridge Rd  
Madison WI 53784-0002

WCDP  
PO Box 6410  
Madison WI 53716-0410

WWWP  
PO Box 6645  
Madison WI 53716-0645

**INSTRUCTIONS**

Type or print clearly. Enter the following information from the provider's Remittance Advice or the 835 Health Care Claim Payment/Advice (835) transaction.

**SECTION I — BILLING PROVIDER AND MEMBER INFORMATION**

Check the appropriate box to indicate the applicable program to which the adjustment request is being submitted.

**Element 1 — Name — Billing Provider**

Enter the billing provider's name.

**Element 2 — Billing Provider's Provider ID**

Enter the Provider ID of the billing provider.

**Element 3 — Name — Member**

Enter the complete name of the member for whom payment was received.

**Element 4 — Member Identification Number**

Enter the member ID.

## SECTION II — CLAIM INFORMATION (Non-Pharmacy)

### Element 5 — Remittance Advice or X12 835 Health Care Claim Payment / Advice, Check Issue Date, or Payment Date

Enter the date of the remittance advice or the payment date or check issue date from the 835.

### Element 6 — Internal Control Number / Payer Claim Control Number

Enter the internal control number (ICN) from the remittance advice or the payer claim control number from the 835 of the paid or allowed claim. (When adjusting a previously adjusted claim, use the ICN assigned to the most recently processed claim or adjustment.)

### Add a new service line(s).

Check if submitting an adjustment to add a service line(s) to a paid or allowed claim. Enter the complete information the provider is requesting to be added to the claim in Elements 7 through 15.

### Correct detail on previously paid/allowed claim.

Check if correcting details on a previously paid or allowed claim.

### Element 7 — Date(s) of Service

Enter to and from date(s) of service (DOS) in MM/DD/YY or MM/DD/CCYY format. If the service was provided on only one DOS, enter the date under "From." Leave "To" blank or re-enter the "From" date. If grouping services, the place of service, procedure code, charges, and rendering provider for each line must be identical for that service line. Grouping is allowed only for services on consecutive dates. The number of days must correspond to the number of units in Element 24G of the 1500 Health Insurance Claim Form.

### Element 8 — POS

Enter the appropriate two-digit POS code for each service.

### Element 9 — Procedure / NDC / Revenue Code

Enter the single most appropriate procedure code. ForwardHealth will deny claims received without an appropriate procedure code, National Drug Code (NDC), or revenue code. When adjusting a detail that includes an NDC and a "J" code, providers are required to attach a paper claim form to the adjustment request and follow the claim form instructions for submitting the NDC.

### Element 10 — Modifiers 1-4

Enter the appropriate modifier(s).

### Element 11 — Billed Amount

Enter the total billed amount for each line item. Providers are to indicate their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to ForwardHealth benefits.

### Element 12 — Unit Quantity

Enter the number of units. Only include a decimal when billing fractions (e.g., 1.50).

### Element 13 — Family Planning Indicator

Enter a "Y" for each family planning procedure when applicable.

### Element 14 — EMG

Emergency Indicator. Enter a "Y" for each procedure performed as an emergency. If the procedure is not an emergency, leave this element blank. Dental providers should continue to enter an "E" to indicate each procedure performed as an emergency.

### Element 15 — Rendering Provider Number

Health care providers may enter their NPI and taxonomy code. Non-healthcare providers may enter their Provider ID.

## SECTION II — CLAIM INFORMATION (Pharmacy)

### Element 5 — Remittance Advice or X12 835 Health Care Claim Payment / Advice, Check Issue Date, or Payment Date

Enter the date of the remittance advice or the payment date or check issue date from the 835.

### Element 6 — Internal Control Number / Payer Claim Control Number

Enter the ICN from the remittance advice or the payer claim control number from the 835 of the paid or allowed claim. (When adjusting a previously adjusted claim, use the ICN assigned to the most recently processed claim or adjustment.)

### Add a new service line(s).

Check if submitting an adjustment to add a service line(s) to a paid or allowed claim. Enter the complete information the provider is requesting to be added to the claim in Elements 7 through 15.

**Correct detail on previously paid/allowed claim.**

Check if correcting details on a previously paid or allowed claim.

**Element 7 — Date(s) of Service**

Enter the date filled in MM/DD/YY or MM/DD/CCYY format for each NDC in the "From" field.

**Element 8 — POS**

Enter the appropriate two-digit National Council for Prescription Drug Programs (NCPDP) patient location code for each NDC billed.

**Element 9 — Procedure / NDC / Revenue Code**

Enter the NDC. Claims received without an appropriate NDC will be denied.

**Element 10 — Modifiers 1-4**

Not applicable for pharmacy claims.

**Element 11 — Billed Amount**

Enter the total billed amount for each line item. Providers are to indicate their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to ForwardHealth benefits.

**Element 12 — Unit Quantity**

Enter the metric decimal quantity in the specified unit of measure according to the ForwardHealth drug file. Quantities billed should be rounded to two decimal places (i.e., nearest hundredth).

**Element 13 — Family Planning Indicator**

Not applicable for pharmacy claims.

**Element 14 — EMG**

Not applicable for pharmacy claims.

**Element 15 — Rendering Provider Number**

Not applicable for pharmacy claims.

**SECTION III — ADJUSTMENT INFORMATION**

*Note:* Additional information necessary for adjustment/reconsideration of an NDC should be included in Element 16 under "Other/comments."

**Element 16 — Reason for Adjustment**

Check one of the following boxes indicating the provider's reason for submitting the adjustment:

- *Consultant review requested.* Indicate if there are extenuating circumstances or complicated or new procedures and attach a history and physical operative or anesthesia report.
- *Recoup entire payment.* This would include claims billed in error or completely paid by another insurance carrier.
- *Other insurance payment.* Enter the amount paid by the other insurance carrier.
- *Copayment deducted in error.* Indicate if the member was a nursing home resident on the DOS, the correct number of covered service days, or if an emergency service was provided.
- *Medicare reconsideration.* Attach both the original and the new Medicare remittance information.
- *Correct service line.* Provide specific information in the comments section or attach a corrected claim.
- *Other / comments.* Add any clarifying information not included above.\*

**Element 17 — Signature — Billing Provider\*\***

Authorized signature of the billing provider.

**Element 18 — Date Signed\*\***

Use either the MM/DD/YY format or the MM/DD/CCYY format.

**Element 19 — Claim Form Attached**

Indicate if a corrected claim form is attached. Although this is optional, ForwardHealth encourages providers to attach a corrected claim form when adding additional service lines or correcting information from a previously adjusted claim.

\* This section of the Adjustment/Reconsideration Request form should be used for any pharmacy-specific fields (e.g., prescription number) pertaining to the NDC being adjusted or added to a previously processed claim. If either the Submission Clarification Code or the Unit Dose value is being adjusted on a drug claim, both values must be indicated in the comment area, even if one is not being adjusted.

\*\* If the date or signature is missing on the Adjustment/Reconsideration Request form, the adjustment request will be denied.

**ATTACHMENT 5**  
**Adjustment/Reconsideration Request**  
**(for photocopying)**

(A copy of the "Adjustment/Reconsideration Request" is located on the following page.)

**FORWARDHEALTH  
 ADJUSTMENT / RECONSIDERATION REQUEST**

**Instructions:** Type or print clearly. Refer to the Adjustment/Reconsideration Request Completion Instructions, F-13046A, for information about completing this form.

**SECTION I — BILLING PROVIDER AND MEMBER INFORMATION**

Indicate applicable program.

BadgerCare Plus / SeniorCare / Wisconsin Medicaid     WCDP     WWWP

1. Name — Billing Provider	2. Billing Provider's Provider ID
3. Name — Member	4. Member Identification Number

**SECTION II — CLAIM INFORMATION**

5. Remittance Advice or X12 835 Health Care Claim Payment / Advice, Check Issue Date, or Payment Date	6. Internal Control Number / Payer Claim Control Number
---	---

- Add a new service line(s) to previously paid / allowed claim (in Elements 7-15, enter information to be added).  
 Correct detail on previously paid / allowed claim (in 7-12, enter information as it appears on Remittance Advice or 835).

7. Date(s) of Service		8. POS	9. Procedure / NDC / Revenue Code	10. Modifiers 1-4				11. Billed Amount	12. Unit Quantity	13. Family Planning Indicator	14. EMG	15. Rendering Provider Number
From	To			Mod 1	Mod 2	Mod 3	Mod 4					

**SECTION III — ADJUSTMENT INFORMATION**

16. Reason for Adjustment
- Consultant review requested.
  - Recoup entire payment.
  - Other insurance payment (OI-P) \$ \_\_\_\_\_.
  - Copayment deducted in error     Member in nursing home.     Covered days \_\_\_\_\_.     Emergency.
  - Medicare reconsideration. (Attach the Medicare remittance information.)
  - Correct service line. (Provide specific information in the comments section below or attach a corrected claim.)
  - Other / comments.

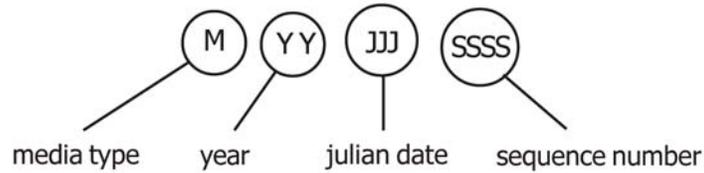
17. <b>SIGNATURE</b> — Billing Provider	18. Date Signed
Mail completed form to the applicable address: BadgerCare Plus                      WCDP                                      WWWP Claims and Adjustments    PO Box 6410                      PO Box 6645 6406 Bridge Rd                      Madison WI 53716-0410              Madison WI 53716-0645 Madison WI 53784-0002	19. Claim Form Attached (Optional) <input type="checkbox"/> Yes <input type="checkbox"/> No Maintain a copy of this form for your records.



# ATTACHMENT 6

## Interpreting Prior Authorization Numbers

Each prior authorization (PA) request is assigned a unique PA number. This number identifies valuable information about the PA. The following diagram and table provide detailed information about interpreting the PA number.



Type of Number and Description	Applicable Numbers and Description
<p><b>Media</b> — One digit indicates media type.</p>	<p>Digits are identified as follows:            1 = paper; 2 = fax; 3 = Specialized Transmission Approval Technology-Prior Authorization (STAT-PA); 4 = STAT-PA; 5 = Portal; 6 = Portal; 7 = National Council for Prescription Drug Programs (NCPDP) transaction</p>
<p><b>Year</b> — Two digits indicate the year ForwardHealth received the PA request.</p>	<p>For example, the year 2008 would appear as 08.</p>
<p><b>Julian date</b> — Three digits indicate the day of the year, by Julian date, that ForwardHealth received the PA request.</p>	<p>For example, February 3 would appear as 034.</p>
<p><b>Sequence number</b> — Four digits indicate the sequence number.</p>	<p>The sequence number is used internally by ForwardHealth.</p>

# ATTACHMENT 7

## Prior Authorization Request Form (PA/RF) Completion Instructions for Enteral Nutrition Products

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. The use of this form is mandatory to receive PA of certain procedures/services/items. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests, along with the Prior Authorization/Enteral Nutrition Product Attachment (PA/ENPA), F-11054, by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

### SECTION I — PROVIDER INFORMATION

#### Element 1 — HealthCheck “Other Services” and Wisconsin Chronic Disease Program (WCDP)

Enter an “X” in the box next to HealthCheck “Other Services” if the services requested on the Prior Authorization Request Form (PA/RF), F-11018, are for HealthCheck “Other Services.” Enter an “X” in the box next to Wisconsin Chronic Disease Program (WCDP) if the services requested on the PA/RF are for a WCDP member.

#### Element 2 — Process Type

Enter process type “131” for enteral nutrition products. The process type is a three-digit code used to identify a category of service requested. Prior authorization requests will be returned without adjudication if no process type is indicated.

#### Element 3 — Telephone Number — Billing Provider

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

#### Element 4 — Name and Address — Billing Provider

Enter the name and complete address (street, city, state, and ZIP+4 code) of the billing provider. Providers are required to include both the ZIP code and four-digit extension for timely and accurate billing. The name listed in this element must correspond with the billing provider number listed in Element 5a.

#### Element 5a — Billing Provider Number

Enter the National Provider Identifier (NPI) of the billing provider. The NPI in this element must correspond with the provider name listed in Element 4.

#### Element 5b — Billing Provider Taxonomy Code

Enter the national 10-digit alphanumeric taxonomy code that corresponds to the NPI in Element 5a.

### SECTION II — MEMBER INFORMATION

#### Element 6 — Member Identification Number

Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth identification card or Wisconsin’s Enrollment Verification System (EVS) to obtain the correct number.

**Element 7 — Date of Birth — Member**

Enter the member's date of birth in MM/DD/CCYY format.

**Element 8 — Address — Member**

Enter the complete address of the member's place of residence, including the street, city, state, and ZIP code. If the member is a resident of a nursing home or other facility, include the name of the nursing home or facility.

**Element 9 — Name — Member**

Enter the member's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

**Element 10 — Gender — Member**

Enter an "X" in the appropriate box to specify male or female.

**SECTION III — DIAGNOSIS / TREATMENT INFORMATION****Element 11 — Diagnosis — Primary Code and Description**

Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested.

**Element 12 — Start Date — SOI (not required)****Element 13 — First Date of Treatment — SOI (not required)****Element 14 — Diagnosis — Secondary Code and Description (not required)****Element 15 — Requested PA Start Date**

Enter the requested start date for service(s) in MM/DD/CCYY format, if a specific start date is requested.

**Element 16 — Rendering Provider Number (not required)****Element 17 — Rendering Provider Taxonomy Code (not required)****Element 18 — Procedure Code**

Enter the appropriate Healthcare Common Procedure Coding System (HCPCS) code for each service/product/item requested.

**Element 19 — Modifiers**

Enter the modifier(s) corresponding to the procedure code listed if a modifier is required.

**Element 20 — POS**

Enter the appropriate place of service (POS) code designating where the requested service/procedure/item would be provided/performed/dispensed.

**Element 21 — Description of Service**

Enter a written description corresponding to the appropriate HCPCS code for each service/product/item requested.

**Element 22 — QR**

Enter the appropriate quantity number of units for the product requested, with one unit = 100 calories.

**Element 23 — Charge**

Enter the provider's usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1.0," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

*Note:* The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to provider *Terms of Reimbursement* issued by the Department of Health Services.

**Element 24 — Total Charges**

Enter the anticipated total charges for this request.

**Element 25 — Signature — Requesting Provider**

The original signature of the provider requesting/performing/dispensing this service/product/item must appear in this element.

**Element 26 — Date Signed**

Enter the month, day, and year the PA/RF was signed (in MM/DD/CCYY format).

**ATTACHMENT 8**  
**Prior Authorization Request Form (PA/RF)**  
**(for photocopying)**

(A copy of the "Prior Authorization Request Form [PA/RF]" is located on the following page.)



**ATTACHMENT 9**  
**Sample Prior Authorization Request Form (PA/RF)**  
**for Wisconsin Chronic Disease Program Enteral**  
**Nutrition Products**

(A sample Prior Authorization Request Form [PA/RF] for Wisconsin Chronic Disease Program enteral nutrition products is located on the following page.)



# **ATTACHMENT 10**

## **Prior Authorization/Enteral Nutrition Product Attachment (PA/ENPA) Completion Instructions**

(A copy of the “Prior Authorization/Enteral Nutrition Product Attachment [PA/ENPA] Completion Instructions” is located on the following pages.)

(This page was intentionally left blank.)

**FORWARDHEALTH  
PRIOR AUTHORIZATION / ENTERAL NUTRITION PRODUCT ATTACHMENT  
(PA/ENPA) COMPLETION INSTRUCTIONS**

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory when requesting PA for certain items. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

Attach the completed Prior Authorization/Enteral Nutrition Product Attachment (PA/ENPA), F-11054, to the Prior Authorization Request Form (PA/RF), F-11018, and send it to ForwardHealth. Providers may submit PA requests by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

**SECTION I — MEMBER INFORMATION**

**Element 1 — Name — Member**

Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

**Element 2 — Date of Birth — Member**

Enter the member's date of birth in MM/DD/CCYY format.

**Element 3 — Member Identification Number**

Enter the member ID. Do not enter any other numbers or letters.

**SECTION II — TYPE OF REQUEST**

**Element 4**

Indicate the start date requested for PA or the date the prescription was filled.

**Element 5**

Check the appropriate box to indicate if this product has been requested previously.

**SECTION III — PRESCRIPTION INFORMATION**

If this section is completed, providers do not need to include a copy of the prescription documentation used to dispense the product requested.

**Element 6 — Product Name**

Enter the product name.

**Element 7 — Quantity Ordered**

Enter the quantity that was ordered.

**Element 8 — Date Order Issued**

Enter the date the order was issued.

**Element 9 — Directions for Use of Product**

Enter the directions for use of the product.

**Element 10 — Daily Dose**

Enter the daily dose.

**Element 11 — Refills**

Enter the amount of refills.

**Element 12 — Name — Prescriber**

Enter the name of the prescriber.

**Element 13 — National Provider Identifier**

Enter the National Provider Identifier of the prescribing provider.

**SECTION IV — CLINICAL INFORMATION**

Include diagnostic, as well as clinical, information explaining the need for the product requested.

**Element 14**

List the member's condition the product is intended to treat. Include the expected length of need. If requesting a renewal or continuation of a previous PA approval, indicate any changes to the clinical condition, progress, or known results to date. Attach another sheet if additional room is needed.

**Element 15**

Indicate source of clinical information.

**Element 16**

Indicate use of the product requested.

**Element 17**

Indicate dosage of the product requested.

**SECTION V — ADDITIONAL INFORMATION REQUIRED FOR ENTERAL NUTRITION SUPPLEMENTS**

**Element 18**

Enter the percentile (children only) and the height. If this is other than the first request, please include the first measurements from the initial request as well as the current information.

**Element 19**

Enter the percentile (children only) and the weight. If this is other than the first request, please include the first measurements from the initial request as well as the current information.

**Element 20**

Enter the amount of weight loss, if any, and within what specific time span the weight was lost.

**Element 21**

Check all that apply.

**Element 22 — Signature — Pharmacist or Dispensing Physician**

The pharmacist/dispenser must review this information and sign this form.

**Element 23 — Date Signed**

Enter the month, day, and year the PA/ENPA was signed in MM/DD/CCYY format.

**ATTACHMENT 11**  
**Prior Authorization/Enteral Nutrition Product**  
**Attachment (PA/ENPA)**  
**(for photocopying)**

(A copy of the “Prior Authorization/Enteral Nutrition Product Attachment [PA/ENPA]” is located on the following pages.)

(This page was intentionally left blank.)

**FORWARDHEALTH**  
**PRIOR AUTHORIZATION / ENTERAL NUTRITION PRODUCT ATTACHMENT (PA/ENPA)**

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.

**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Enteral Nutrition Product Attachment (PA/ENPA) Completion Instructions, F-11054A.

**SECTION I — MEMBER INFORMATION**

1. Name — Member (Last, First, Middle Initial)	2. Date of Birth — Member
3. Member Identification Number	

**SECTION II — TYPE OF REQUEST**

4. Indicate the start date requested or the date the prescription was filled (required).

5. Check one of the following.

This is an initial PA request for this product, for this member, by this provider.

This is a request to renew or extend previously approved PA for therapy using this product.

First PA number \_\_\_\_\_

This is a request to change or add a new Healthcare Common Procedure Coding System (HCPCS) procedure code to a current valid PA.

First PA number \_\_\_\_\_ HCPCS number to add \_\_\_\_\_

**SECTION III — PRESCRIPTION INFORMATION**

6. Product Name	7. Quantity Ordered
8. Date Order Issued	9. Directions for Use of Product
10. Daily Dose	11. Refills
12. Name — Prescriber	13. National Provider Identifier

*Continued*



---

**SECTION IV — CLINICAL INFORMATION**

---

14. List the member's condition the prescribed drug is intended to treat. Include the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis for pharmaceutical care members. Include the expected length of need. If requesting a renewal or continuation of a previous PA approval, indicate any changes to the clinical condition, progress, or known results to date. Attach another sheet if additional room is needed.

---

15. Indicate source for clinical information (check one).

- This information was primarily obtained from the prescriber or prescription order.
- This information was primarily obtained from the member.
- This information was primarily obtained from some other source (specify). \_\_\_\_\_

---

16. Use (check one)

- Compendial standards, such as the United States Pharmacopeia — Dispensing Information (USP-DI) or drug package insert, lists the intended use identified above as an expected indication.
- Compendial standards, such as the USP-DI, lists the intended use identified above as a [bracketed] accepted application.
- Compendial standards, such as the USP-DI or drug package insert, lists the intended use identified above as an expected use.
- The intended use above is not listed in compendial standards. Peer-reviewed clinical literature is attached or referenced. (Reference — include publication name, date, and page number.)

---

17. Dose (check one)

- The daily dose and duration are within compendial standards of general prescribing or dosing limits for the indicated use.
  - The daily dose and duration are **not** within compendial standards of general prescribing or dosing limits for the intended use. Attach or reference peer-reviewed literature that indicates this dose is appropriate, or document the medical necessity of this dosing difference. (Reference — include publication name, date, and page number.)
- 

*Continued*

---

**SECTION V — ADDITIONAL INFORMATION REQUIRED FOR ENTERAL NUTRITION SUPPLEMENTS**

---

18. Indicate percentile (children only) and height.

19. Indicate percentile (children only) and weight.

---

20. Indicate the amount of weight loss, if any, and within what specific time span the weight was lost.

---

21. Check all that apply.

- This member is tube-fed.
- If not tube-fed, number of Kcal prescribed per day \_\_\_\_\_. Percent of total calories from this supplement \_\_\_\_\_%.
- This member can consume most normal table foods.
- This member can consume softened, mashed, or pureed food, or food prepared by blender.
- This member has a clinical condition, as indicated in Section IV, which prevents him or her from consuming normal table food, softened, mashed, or pureed food, or food prepared by blender.
- Comprehensive documentation of this member's condition is presented previously in Section IV.
- This member is eligible for food stamps.
- This product or a similar product can be obtained from the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

---

22. **SIGNATURE** — Pharmacist or Dispensing Physician

23. Date Signed

---

# **ATTACHMENT 12**

## **Prior Authorization Amendment Request Completion Instructions**

(A copy of the “Prior Authorization Amendment Request Completion Instructions” is located on the following pages.)

## FORWARDHEALTH PRIOR AUTHORIZATION AMENDMENT REQUEST COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about /program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

Providers are required to use the Prior Authorization Amendment Request, F-11042, to request an amendment to a PA. The use of this form is mandatory when requesting an amendment to a PA. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization Amendment Request to the PA Decision Notice of the PA to be amended along with physician's orders, if applicable, (within 90 days of the dated signature) and send it to ForwardHealth. Providers may submit the Prior Authorization Amendment Request to ForwardHealth by fax at (608) 221-8616 or by mail to the following address:

ForwardHealth  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

### SECTION I — MEMBER INFORMATION

**Element 1 — Original PA Number**

Enter the unique PA number from the original PA to be amended.

**Element 2 — Process Type**

Enter the process type as indicated on the PA to be amended.

**Element 3 — Member Identification Number**

Enter the member ID as indicated on the PA to be amended.

**Element 4 — Name — Member**

Enter the name of the member as indicated on the PA to be amended.

### SECTION II — PROVIDER INFORMATION

**Element 5 — Billing Provider Number**

Enter the billing provider number as indicated on the PA to be amended.

**Element 6 — Name — Billing Provider**

Enter the name of the billing provider as indicated on the PA to be amended.

**SECTION III — AMENDMENT INFORMATION**

**Element 7 — Address — Billing Provider**

Enter the address of the billing provider (include street, city, state, and ZIP+4 code) as indicated on the PA to be amended.

**Element 8 — Requested Start Date**

Enter the requested start date for the amendment in MM/DD/CCYY format if a specific start date is required.

**Element 9 — Requested End Date (If Different from Expiration Date of Current PA)**

Enter the requested end date for the amendment in MM/DD/CCYY format if the end date is different that the current expiration date.

**Element 10 — Reasons for Amendment Request**

Enter an "X" in the box next to each reason for the amendment request. Check all that apply.

**Element 11 — Description and Justification for Requested Change**

Enter the specifics and supporting rationale of the amendment request related to each reason indicated in Element 10.

**Element 12 — Are Attachments Included?**

Enter an "X" in the appropriate box to indicate if attachments are or are not included with the amendment request. If Yes, specify all attachments that are included.

**Element 13 — Signature — Requesting Provider**

Enter the signature of the provider that requested the original PA.

**Element 14 — Date Signed — Requesting Provider**

Enter the date the amendment request was signed by the requesting provider in MM/DD/CCYY format.

**ATTACHMENT 13**  
**Prior Authorization Amendment Request**  
**(for photocopying)**

(A copy of the "Prior Authorization Amendment Request" is located on the following page.)

**FORWARDHEALTH  
PRIOR AUTHORIZATION AMENDMENT REQUEST**

Providers may submit prior authorization (PA) requests with attachments to ForwardHealth by fax at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Refer to the Prior Authorization Amendment Request Completion Instructions, F-11042A, for detailed information on completing this form.

**SECTION I — MEMBER INFORMATION**

1. Original PA Number	2. Process Type	3. Member Identification Number
4. Name — Member (Last, First, Middle Initial)		

**SECTION II — PROVIDER INFORMATION**

5. Billing Provider Number	7. Address — Billing Provider (Street, City, State, ZIP+4 Code)
6. Name — Billing Provider	

**SECTION III — AMENDMENT INFORMATION**

8. Requested Start Date	9. Requested End Date (If Different from Expiration Date of Current PA)
-------------------------	---

10. Reasons for Amendment Request (Check All That Apply)

<input type="checkbox"/> Change Billing Provider Number	<input type="checkbox"/> Add Procedure Code / Modifier
<input type="checkbox"/> Change Procedure Code / Modifier	<input type="checkbox"/> Change Diagnosis Code
<input type="checkbox"/> Change Grant or Expiration Date	<input type="checkbox"/> Discontinue PA
<input type="checkbox"/> Change Quantity	<input type="checkbox"/> Other (Specify) _____

11. Description and Justification for Requested Change

12. Are Attachments Included?  Yes  No  
If Yes, specify attachments below.

13. <b>SIGNATURE</b> — Requesting Provider	14. Date Signed — Requesting Provider
--	---------------------------------------

